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ABSTRACT

This report explores policy initiatives, priorities, and plans of action recommended to policymakers with respect to a commitment to education for youth on prevention of Human Immunodeficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS). Young people with AIDS/HIV infection, can be offered compassion, hope, and support. Uninfected adolescents must be provided with accurate information about AIDS/HIV and with skills to make healthy decisions in order to prevent HIV infection. This report is both a resource and a challenge, directed to local communities, to create a national campaign on adolescents, AIDS, and HIV. The information in the report is intended to help program planners, educators, and policymakers develop an effective community response to the HIV epidemic. The report is divided into 6 sections: (1) identifying and naming an epidemic; (2) adolescents, AIDS, and HIV; (3) goals of HIV prevention; (4) information for HIV prevention; (5) delivering the message; and (6) HIV education: a shared community responsibility. Forty references and 68 organizational resources are listed. (LL)

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a community wide responsibility

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Center for Population Options

Adolescents AIDS and HIV

A community wide responsibility

Center for Population Options
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September 9, 1989

To the Reader:

As a youth I felt immortal to most all of the world's pitfalls. I had determination, energy and dreams. I was fairly well educated and strong on survival instincts. Living in a rural area and being liked by most people also give you a sense of security. A security especially against AIDS. AIDS was something that only affected people in San Francisco or New York City, not Mansfield, Missouri.

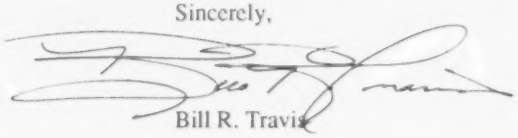
I had been in school, out-of-state, and moved home to Mansfield with cancer and AIDS. That was in 1986. The community response was varied. It was mostly judgmental and uncaring. Inward was the only direction I could turn. To the community, even my family was suspected of carrying the disease and each member of my family had his/her own fears.

Everyone needs the time to consider their personal feelings. What I would ask of each of you, as individuals and communities, is to view and react to this problem from the infected person's perspective.

AIDS can, has and will continue to happen in each of our communities. HIV is a virus that knows no geographic nor socioeconomic boundaries. Efforts to care for those already infected, their family, and friends should be continuing and expanded. Compassion is our only comfort. Comprehensive community-based prevention efforts are our strongest weapon in assaulting the further spread of HIV.

The youth of today and tomorrow are relying on you. In reality, no matter where we call home, we are all people living with AIDS.

Sincerely,



Bill R. Travis

Bill Travis, 25, is a person with AIDS. Medical evidence suggests he was infected with HIV as a teenager. Over the past three years Bill has worked hard to bring the message of prevention to thousands of young people, and they all have benefited from his willingness to talk honestly about himself and the disease AIDS.

Statement

A Commitment to Education for Youth on Prevention of HIV Infection and AIDS

The threat of HIV infection and AIDS has changed dramatically the world in which the young grow up. Current research indicates that HIV may have an incubation period of up to ten (10) years. That statistic suggests that those people in their twenties diagnosed with AIDS, (approximately one-fifth of all diagnosed AIDS cases), probably became infected with HIV as teenagers. To young people with AIDS/HIV infection, we can offer compassion, hope, and support. To other adolescents, we can give accurate information about AIDS/HIV and provide them with the skills to make healthy decisions and to protect them from HIV infection.

As individuals and agencies committed to a healthier future for America's young people, we believe that the greatest weapon against HIV infection is education. Our children have a right to straightforward, accurate information about HIV infection and how to prevent it. Education is essential in helping youth to overcome prejudice and irrational fear. Therefore, we urge policymakers to consider the following:

- For adolescent-targeted education about AIDS/HIV prevention to be effective it must be an integrated, comprehensive community effort involving parents, teachers, community leaders and all organizations that touch the lives of youth.
- Education must provide the practical means for preventing HIV infection through factual and consistent messages devoid of moralizing, bias or censorship. HIV education must be a part of comprehensive school-based health education in order to reach the maximum number of in-school youth.
- Adequate public and private financial support is essential to educate out-of-school youth who, because of their behaviors, are at higher risk of misinformation and infection. Priorities must be placed on strategies to reach homeless and street youth with HIV prevention messages and information on how to modify their risky behaviors.
- HIV education must be sensitive to the specific characteristics of the target population — racial, ethnic, cultural, sexual identity, physically challenged and mentally impaired. Youth from the targeted population should be included in the planning and development of materials and programs.

This statement on HIV prevention education needs was developed in a special session at the Center for Population Options' third national conference on Adolescents, AIDS and HIV held on May 11, 1989, in Los Angeles, California. The special session provided conference participants with an opportunity to explore policy initiatives and priorities and to recommend to policymakers a proposed plan of action. If your organization wants to adopt or endorse this statement, please contact the Center for Population Options for more information and details.

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Foreword

Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), is epidemic in the United States, and all sectors of the community are affected. Adolescents, because of their experimentation with both sex and drugs, are notably vulnerable to infection with HIV. The Center for Population Options convened the first national meeting on Adolescents, AIDS and HIV in April 1987, and subsequent national conferences were held in 1988 and 1989. These meetings were attended by leading family planning experts, youth-serving agency representatives, medical and HIV prevention professionals, sexuality educators, youth, and people with AIDS. The meetings provided a forum for these professionals to exchange information and develop strategies to prevent the further spread of HIV among the nation's youth. Each meeting reaffirmed three basic commitments:

- to provide youth with accurate information about HIV;
- to provide youth with the skills needed to make healthy decisions; and,
- to provide compassion, hope, treatment, and support to youth with HIV infection.

Preventing HIV infection among adolescents is a national challenge which can only be solved within individual communities. This report is both a resource and a challenge: to create a national campaign on adolescents, AIDS and HIV directed to local communities. It summarizes key material presented at the three CPO conferences, while also incorporating other information from a wide range of sources about adolescents, AIDS and HIV. The report's purpose is to help program planners, educators, and policymakers develop an effective community response to the HIV epidemic. It is designed to stimulate thinking and action for community involvement and program development on HIV prevention, education and services suitable for young people. The recommendations presented are those of the Center for Population Options, and while they reflect insights and ideas expressed by conference participants, the recommendations do not necessarily represent a consensus among the participants.

For further information on the topics covered in this report or for assistance in developing programs on HIV prevention for adolescents, contact the Center for Population Options at 1012 14th Street N.W., Suite 1200, Washington, D.C., 20005, (202) 347-5700.

Acknowledgements

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I. Identifying and Naming an Epidemic

"The term 'AIDS' is obsolete. 'HIV infection' more correctly defines the problem . . .Continued focus on the label 'AIDS' contributes to the lack of understanding of the importance of HIV infection as the more significant element for taking control of the epidemic."

Report of the Presidential Commission on the Human Immunodeficiency Virus, June 1988

When Americans with puzzling immune deficiency disorders first sought help from doctors in the early 1980s the medical establishment had no name for the baffling condition. An early name for the syndrome was "GRID" (Gay Related Immune Deficiency), coined because many of the first people seeking treatment for the syndrome were homosexual. This label proved inaccurate and damaging because it focused attention on a particular group of people, thereby limiting conceptions and hypotheses about the cause of the syndrome. The inaccuracy of the term "GRID" became obvious when people who were not homosexual began appearing with the same syndrome. Intravenous drug users, babies born to IV drug users, blood transfusion recipients, and heterosexual partners of people who had developed symptoms showed up in medical offices and hospitals. The acronym "AIDS" was then adopted because it described the syndrome more accurately: "Acquired Immunodeficiency Syndrome." In 1983, scientists confirmed what epidemiologists had already inferred: a virus, the Human Immunodeficiency Virus (HIV), causes the syndrome known as AIDS. This discovery made it clear — infection with HIV resulted from specific behaviors with infected individuals, or resulted from situations that exposed one directly to the virus. It did not result from being part of a particular group of people. Public health officials now know that the only sure way to prevent AIDS is to prevent HIV infection.

Prevention efforts are complicated, especially with adolescents, because HIV can be present in the human body for many years before a person begins to show symptoms of infection. To reflect this new understanding of the spectrum of HIV infection and to help educate the general public to avoid infection, medical and health officials have changed the way they talk about the disease. The disease is now more accurately called HIV infection. This new term reflects growth in knowledge about the cause, development and prognosis of the disease. The acronym "AIDS" is now used in a much more limited way to describe the stage of the disease when a person displays symptoms of infections that meet the definition of AIDS established by the U.S. Centers for Disease Control. The Presidential Commission on the Human Immunodeficiency Virus Epidemic stated that the acronym "AIDS" no longer adequately describes the scope of the public health problem society faces. The Commission's final report, in June 1988, stated: "The term 'AIDS' is obsolete. 'HIV infection' more correctly defines the problem . . . Continued focus on the label 'AIDS' contributes to the lack of understanding of the importance of HIV infection as the more significant element for taking control of the epidemic."

In order to "take control of the epidemic" in connection with adolescents, three bodies of information are needed:

- an assessment of the current status of HIV infection in the adolescent population;
- a general understanding of adolescence; and,
- a means to affect adolescent behavior so that infection is avoided.

Unfortunately, data are not complete on adolescents and their behaviors related to HIV infection. While a number of adolescents have been diagnosed with AIDS, the extent of HIV infection in the adolescent population is not known. However, we can infer that adolescents are contracting HIV and many more are at an increasingly high risk of contracting HIV because they engage in risky sexual behaviors or drug use or both. Without further development of treatments, adolescents who are infected with HIV will probably die as young adults from complications related to HIV infection.

Center for Population Options

II. Adolescents, AIDS and HIV

Between July 25, 1988, and July 31, 1989, AIDS cases among 13- to 19-year-olds increased by 43 percent.

As of July 31, 1989, 398 cases of AIDS among teenagers were reported to the U.S. Centers for Disease Control (CDC).(1) However, one-fifth of the people with AIDS are in their twenties.(1) Because, as current HIV infection patterns show, the median interval between infection with HIV and onset of AIDS is nearly 10 years (2), many of these people probably contracted HIV as teenagers, often through sexual behaviors or IV drug use.

Between July 25, 1988, and July 31, 1989, AIDS cases among 13- to 19-year-olds increased by 43 percent.(3, 1) A greater percentage of adolescents than adults with AIDS is female (19 percent vs. 9 percent), and is Black and Hispanic (53 percent vs. 41 percent). (1)

While the incidence of HIV infection among the nation's teenagers remains unknown, the data that has been gathered gives reason for concern.

- Of 1,111 homeless and runaway youth anonymously tested for evidence of HIV infection, 74 (7 percent) indicated signs of the virus, according to the results of a New York City study conducted from October 1987 to October 1988.(4)
- The nation's first survey regarding AIDS in institutions of higher education reveals that HIV infection is a problem for college students today. Of the 16,861 student blood specimens which were included in the survey, 30 indicated signs of HIV infection, for an overall rate of 0.2 percent or 2 per 1000 students. Ten of the nineteen schools participating in the study had rates of infection of zero, while five had rates of 0.4 percent (4 per 1000) to 0.9 percent (9 per 1000).(5)
- Since October 1985, the Department of Defense has conducted routine testing for HIV among civilian applicants as part of their preinduction medical evaluation. The overall prevalence of HIV infection is 0.14 percent (1.4 per 1000) among military applicants screened through September 1988. For individuals aged 17 through 19 the rate is 0.04 percent (.4 per 1000) and for individuals aged 20 through 24 the rate is 0.18 percent (1.8 per 1000). Rates of infection are highest in the Northeast and South Atlantic states.(6)
- Testing for evidence of HIV has been required since March 1987 as part of the medical evaluation of new participants in residential training programs of the Job Corps. Entrants are disadvantaged youth 16 to 21 years of age who are drawn heavily from racial and ethnic minorities and include both inner-city and rural poor. Of the first program entrants tested, through May 1989, 0.4 percent (4 per 1000) indicated signs of HIV.(2)

Adolescents, Sex and Drugs

Many American teenagers engage in sexual intercourse which can transmit HIV. Countless Americans begin having sexual intercourse as adolescents, but most teenagers are not protecting themselves against pregnancy or sexually transmitted diseases. Not all teenagers are heterosexual; some teens experiment with the same and opposite sex partners. Sexual abuse is another potential source of transmission. A number of research studies paint a clear statistical portrait of adolescent sexual behaviors that put adolescents at greater risk of HIV infection. Nationwide, half of the boys and one-third of the girls in high school have had intercourse.(7) The average age of first intercourse throughout the country is around 16 (8), and in some communities, it may be as low as 12.(9)

One in ten teenage girls aged 15 to 19 becomes pregnant each year.(10) In 1988, 10- to 24-year-olds accounted for 61 percent of reported gonorrhea cases and 35 percent of reported syphilis cases in the United States.(11) A recent study shows that people with a history of STDs have a higher incidence of HIV infection than people with no such history.(12)

For most young men and women, the decision to have sex is spontaneous. Only 17 percent of young women and 25 percent of young men report planning their first act of intercourse.(8)

Incidence of homosexual behavior, potentially of a high-risk nature, reported in surveys conducted over the past several decades, occurs among 17 to 37 percent of adolescent males.(13)

One study found that three percent of all teens are currently being sexually abused, and over half of all rape victims are adolescent females.(14)

About one million teenagers run away each year, and an estimated 187,500 runaways are involved in illegal activities, such as drug use, prostitution, solicitation, and drug trafficking.(15) In 1988, 124,709 youth under the age of 18 were arrested for being runaways.(16)

According to the Federal Bureau of Investigation statistics, 18,513 youth through age 18 were arrested in 1988 for prostitution, commercialized vice or sex offenses (excluding forcible rape). An additional 17,671 youth aged 19 through 21 were arrested for the same.(16)

Drug use — IV and non-IV drugs — is a potential source of HIV infection in the adolescent population. Alcohol, crack or other drugs may impair one's ability to make good decisions, especially in sexual situations, such as a person's willingness and ability to use condoms or take other precautions while having sex.(13) Addiction to drugs, especially crack, has led many youth to have sex for money or drugs. Youth sharing needles of any kind are at risk of becoming infected.

Alcohol and drug use is a major risk factor for HIV infection among teens. According to recent studies:

- Alcohol use is a common and a significant risk factor for teens. Among adolescents surveyed in 1987, about one-fourth of eighth grade students (26 percent) and more than one-third of tenth grade students (38 percent) reported having had five or more alcoholic drinks on one occasion during the previous two weeks. (17)
- Last year, 47,252 youth through age 18 — 159 of them under 10 — were arrested for driving under the influence, and an additional 135,118 aged 19 through 21 were arrested for the same.(16)
- About one out of every fifteen adolescents has tried cocaine.(17)

In 1988, 120,825 youth through age 18 were arrested on drug abuse violations; an additional 131,732 youth aged 19 through 21 were arrested for the same.(16)

High school students from four urban sites reported varying rates of intravenous (IV) drug use. From 2.8 percent to 6.3 percent reported ever injecting cocaine, heroin, or other illegal drugs.(18)

The available information is clear. American teenagers are engaging in behaviors that place them at risk for HIV infection. Many have had sexual intercourse and most are not protecting themselves against pregnancy or sexually transmitted diseases. Substance abuse is rampant in the adolescent population and sharing needles of any kind, without proper sterilization, places youth directly at risk for HIV infection. Infection prevention programs are already too late for those teens who have the virus; however, for the majority of youth who are not infected, the need to develop healthy behaviors is crucial.

Understanding Adolescence

Typical adolescent characteristics pose particularly difficult challenges for conducting effective HIV prevention programs. Adolescence is a time of moving away from, and often rejecting the protective influence of parents and other adults. It is a time of experimentation, of testing limits and defining the self. These developmental tasks normally include sexual exploration, both heterosexual and homosexual. All too frequently this sexual exploration takes place in an arena of drug use. Alcohol and drug consumption impair judgment, which may lead to unplanned and unprotected sexual experimentation and exploration.

In formulating an approach predicated on the prevention of HIV infection, it is necessary to understand who the adolescent is. When addressing an adolescent it is important to take into consideration his/her level of knowledge, process of perception, and physical maturity. It is also important to understand how the physical and psychological aspects of adolescence may interplay in the behavior of an adolescent.

Six factors are especially critical to take into account:

1) **All adolescents are not the same.** There are vast social and knowledge differences between early, middle, and late adolescence. Chronological age may not indicate physical and mental development. Students in the same grade in school may be at widely differing levels of physical and social maturity.

2) **Adolescents are not adults.** Adolescents do not have the cognitive abilities adults do. Adults have the ability to project into the future as well as to call on past experience in making current decisions. Youth have to be accepted as they are with the abilities they have now.

3) **Teenagers are concrete rather than abstract thinkers.** They think about the present in concrete terms, and often have difficulty conceiving probable risks and future events. Because current HIV infection patterns indicate that the median interval between infection with HIV and the development of AIDS is nearly ten years, it will be difficult to help young people understand the risk to them. A ten-year period is a very long time to a teen who has difficulty making plans for next summer or even next week.

Because current HIV infection patterns indicate that the median interval between infection with HIV and the development of AIDS is nearly ten years, it will be difficult to help young people understand the risk to them.

4) **Seeking a sexual identity is a major developmental task of adolescence.** Some of the most profound conflicts during adolescence center around sexuality and gender roles. While their bodies mature, adolescents are wrestling with what it means to be male or female. They are experimenting with and learning new roles as they also experience peer pressure to conform to gender role stereotypes. Some teenagers become sexually active; some have intercourse. Some teenagers experiment with both heterosexual and homosexual experiences. Other teens abstain from sexual activity. But a normal part of the adolescent development process is experimentation with one's sexuality.

5) **Many teenagers feel immortal and invulnerable.** Adolescence is a time of risk-taking. Many teens drink and drive, shoplift, try drugs, and have sex without protecting themselves from pregnancy and STDs because consequences are not perceived as real. Teens can and do understand that being safer now can prevent HIV infection, but they still believe and act like, "It won't happen to me."

6) **Teenagers, especially early and middle adolescents, often feel great pressure to conform.** Teenagers want to be like every other teen, especially those in the "in" group. Teenagers may be better motivated to change behavior if educators concentrate on changing the norms of the peer group rather than trying to change individual teens' actions in a way contrary to the peer group's norms.

Psychological influences on adolescents are important to consider when exploring strategies to help adolescents develop behaviors that protect them from HIV infection.

These basic psychological influences are:

The family. The most useful definition of family, in the context of HIV prevention, is a broad, functional one seen from the adolescent's point of view. The adolescent's functional family may be defined conventionally or not and may involve individuals who are not blood relatives. It may be mother and father and two half siblings; it may be two mothers, two fathers and eight grandparents and a number of half, quarter, and whole siblings; it might be a number of people within the community; it may be social institutions; it is a large number of people. It is within the individually defined family that youth learn most of the skills necessary to negotiate adolescence.

School and other institutions. Next to the family, the second most important institution in the adolescent's world is the school. Formal education is a major determinant of an adolescent's functional identity. The definition of school — fundamentally, a locus for learning — also encompasses youth-serving agencies and community-based programs in which youth acquire information and skills in a somewhat formal way and develop relationships and negotiating skills with adults and peers who are not "family."

Peers. For the adolescent, the peer group is made up of individuals who are all experiencing instability. Parents/family remain important, but they cannot provide all that is needed for the creation of a personal identity. While the slow process of disengagement from the family is going on, adolescents need each other for support and security. During early adolescence the focus of friendship is on activities rather than on identity and personality. Middle adolescence is marked by the formation of cliques — youth similarly situated in the social structure based on shared attitudes and interest. Late adolescence sees the emergence of individuality — a decrease in the importance and stability of cliques.(19)

The **media.** The media has the ability to establish standards for adolescents. Such standards may be modified by information and values that come from the broadly defined family, but they are nevertheless extremely important in formulating how adolescence is negotiated and the patterns of behavior that will be established. Especially during early adolescence, the media provides role and behavior models to the adolescent. These models give important information about how adolescents should act. They present behaviors, express desires and emotions, and resolve conflicts. In the media, youth not only see individuals to emulate; they also see — or think they see — how adults handle life, and what actions or behaviors define "real" adulthood.

III. Goals of HIV Prevention

Strategies & Specifics

Goals...

HIV prevention programs for adolescents should have six primary goals:

1) To present accurate information and reduce misinformation about HIV infection and its modes of transmission.
2) To help teenagers delay the initiation of sexual intercourse.
3) To ensure that teenagers who are having any type of intercourse use condoms consistently and effectively.
4) To reduce experimentation with drugs, including alcohol, and to prevent intravenous drug use.
5) To provide teenagers with information on community resources and services available to them.
6) To promote compassion for people with AIDS/HIV infection, their family, and friends.

The public has strongly supported school-based sexuality education for decades, but teenagers still lack full, accurate knowledge regarding contraception and the transmission of sexually transmitted diseases, including HIV. Even when teens have accurate knowledge they fail to act upon that knowledge. The most recent statistics indicate vast improvements in knowledge about HIV, compared to studies conducted in 1985 and 1986, but the need for greater awareness, understanding and more action is abundantly — and urgently — clear.

A 1943 Gallup poll found that 70 percent of adults supported sexuality education.(20) More than forty years later, a 1988 Louis Harris and Associates poll found almost nine out of ten American adults endorse school sex education. In addition, eight out of ten adults favor school referral of sexually active teenagers to outside family planning clinics, and slightly more than seven out of ten adults favor making contraceptives available in school clinics.(21)

A 1987 NBC poll found that even more — 91 percent — of adults approved of teaching "AIDS prevention" to children in public school. Among these same adults, 79 percent favor television advertising to promote the use of condoms for HIV prevention.(22)

Urban studies indicate that while students are well informed about how HIV is transmitted, they are confused about how the virus is *not* spread and are likely to believe that HIV can be spread through casual contact. Reports indicate that the vast majority of students knew that HIV is transmitted by sharing needles or syringes used to inject drugs (83.8 to 98.4 percent) or through sexual intercourse (88.3 to 98.1 percent). However, these same studies show that only 27.8 to 53.3 percent of the students knew one is not placed in danger of HIV infection by giving blood; 28.9 to 46.8 percent knew that mosquito or other insect bites do not transmit HIV; and just 41.8 to 64.6 percent knew that HIV infection is not caught by using public toilets. A higher percentage, 49.6 to 75.4 percent, knew that having a blood test does not put one at risk, while 85.5 to 95.6 percent knew that the virus is not transmitted through shaking hands.(18) While some messages have gotten through, others have clearly not, or have become distorted. Clearly, continued and persistent education is needed.

The 1987 National Adolescent Student Health Survey of eighth and tenth graders revealed that more than one-third of the students did not know the common early signs of sexually transmitted diseases (STDs). More than one-half of them did not know that birth control pills offer no protection against STDs. Two-thirds (67 percent) did not know that washing after sex is an ineffective way of avoiding STDs.(17)

In a national study of school administrators, 98 percent indicated that AIDS instruction belongs in the regular school curriculum. Eighty-five percent believe that a discussion of "safe sex" along with abstinence is more realistic than abstinence alone.(23)

Almost all teens (89.0 to 96.8 percent) in studies conducted in urban areas agree that it is important for students their age to receive AIDS education through the school curriculum.(18)

As this generation of American youth faces the challenges of adolescence, it faces an additional challenge — avoiding HIV infection. The HIV epidemic poses a psychological challenge to youth; the threat of HIV infection creates powerful questions about life, sexuality and death. Teenagers often hear rumors about AIDS and HIV infection, and develop faulty conceptions about the syndrome and the means of viral transmission. Such ignorance can accelerate the spread of HIV among teens; it can also develop into unfounded fears about sexual involvement. Teenagers who think they have the facts about HIV may also develop prejudice against people with AIDS/HIV infection. Young people have the right to know how to protect themselves against HIV. They also need to explore the dilemmas the HIV epidemic poses for themselves and society.

Goals...

1) Accurate Information and the Elimination of Misinformation

Because teenagers are exposed to a barrage of information and misinformation about sexuality and the HIV epidemic, programs are urgently needed to counter the misinformation and reduce the fear surrounding the disease. Most teenagers lack accurate knowledge about HIV and the transmission of HIV. Many incorrectly believe that they can get the virus from food handlers, toilet seats, and from being in a room with gay people. Before teenagers can develop behaviors to protect themselves they need to know the facts.

2) Help Teenagers Delay

Teenagers must be assisted in developing the necessary decision-making and negotiating skills to delay sexual intercourse. Teenagers are becoming biologically mature and sexually active at an earlier and earlier age. Two hundred years ago, young women in the U.S. had their first menstrual period at about seventeen; by the Civil War, that age had dropped to fifteen-and-a-half. Today it's dropped to between eleven-and-a-half and twelve, with a decrease of roughly three months for every decade since the beginning of this century.(24) Most adolescents have neither the knowledge nor emotional capacity to handle the implications of too-early sexual relationships. Teenagers need more than information alone; they need to develop communication, decision-making and goal-setting skills to delay sexual intercourse until they are both emotionally and cognitively mature. To enable teenagers to successfully delay intercourse, options and alternatives for sexual expression other than intercourse must become part of their decision-making process and of sexuality education.

3) Ensure Condom Use

Teenagers having sexual intercourse should use condoms each and every time they have intercourse. Condom use is quite low among American teenagers. Only 24 percent of women aged 15 to 19 use any kind of contraception consistently, and of that 24 percent, only 21 percent protect themselves against STDs by using condoms.(25) Teenagers need education about condoms, about how to use them, and about where they can be obtained easily. Such education would help teenagers prevent pregnancies and the spread of sexually transmitted diseases, including HIV infection.

4) Prevent Drug Use

All HIV education programs should warn teenagers about the dangers of drug use and misuse, especially intravenous (IV) drugs and crack/cocaine. The widespread use of alcohol throughout the nation by increasingly younger teens requires that teens and preteens be taught about its effects. Teenagers need to understand that the use of alcohol or drugs may impair their ability to make good decisions, especially in sexual situations, and that sharing any kind of needles puts them at great risk of becoming infected with HIV through blood products. Programs working with drug-abusing youth must include information on both treatment of drug addiction and sterilization of needles and syringes.

5) Provide Community Resources

As the threat of HIV infection among young people grows, so does the need for adequate health care, legal services, mental health counseling, and other support services, to be carefully coordinated within communities. While many localities provide special clinics and services for adolescents, many more do not. Cooperation among public agencies and private service organizations is essential to ensure that services are accessible to youth. Teenagers should have information about the availability of these services, how to use them, their cost, and their location.

6) Develop Compassion

Organizations have had to confront unfounded fears of contagion on the part of youth, teachers, school employees, health-care workers, waiters and cooks with AIDS/HIV infection. Misinformation has created confusion, fear, and prejudice, causing workers who care for people with AIDS/HIV infection to be shunned by family and friends. Education programs can reduce these misperceptions and fears by providing factual information about the disease and by fostering compassion for people with AIDS/HIV infection, their families, friends, and co-workers.

IV. Information for HIV Prevention

Strategies & Specifics

For openers . . .

One way to begin a discussion of HIV prevention and education is by saying, "We are going to be discussing AIDS and HIV, the virus that causes AIDS. The HIV epidemic is a national emergency. All of us need to know more about this disease and how it is transmitted. We will be talking later about prevention. You may not need this information now or ever, but it is important for everyone to listen so that they can be helpful to a friend, or family member, or yourself in the future."

Effective HIV prevention and education programs will vary in content, format, setting, and goals. Generic programs designed for all within a 12 through 19 age range will have limited impact. All formal HIV prevention and education programs should solicit parental input at all stages. Parents/families should have the opportunity to review curricula, meet leaders, and observe educational sessions. Programs can include homework assignments that will encourage family communication. Some programs will only be able to institute single session lectures; others will be comprehensive. Regardless of the length of the program, HIV education programs should emphasize certain basic information, including:

- **How HIV is Transmitted,** including sexual transmission; transmission through the exchange of blood products (includes drug use); and perinatal, intrapartum, and postpartum transmission from mother to child.
- **How HIV is *not* Transmitted,** including clear information about the overwhelming evidence that HIV is not transmitted through casual contact.
- **Protection From HIV,** including abstinence from intercourse and IV drug use, and the discussion of risk reduction behaviors for those who engage in or may soon engage in sexual intercourse.
- **Information on Additional Resources,** including community resources available for information and services.

The ideal program integrates HIV education into existing comprehensive health and sexuality education programs. Prevention information is discussed following training on communication skills, drug prevention, and ways to resist peer pressure. The program includes ample opportunity for behavioral skill development, including such issues as how to say "no" or "wait" in pressure situations, talking about the decision to have sex with a partner and negotiating limitations, condom use, personal risk for HIV infection, and how to locate community resources. The ideal educational program includes many varied activities to increase knowledge, explore attitudes, and facilitate desired behavioral outcomes.

"Criteria for Evaluating an AIDS Curriculum," a publication created by the National Coalition of Advocates for Students (NCAS), outlines appropriate curriculum content and development and implementation strategies for HIV education. It includes suggestions for matching approaches for HIV education with stages of childhood development. NCAS suggests five basic principles for all programs to follow:

1) Offer simple, clear and factual information in terms students can understand.

2) Emphasize "safer sex" behaviors — including abstinence and the use of condoms during any type of sexual intercourse — over the biomedical aspects of HIV.

3) Discuss the dangers of IV drug use, especially the sharing of needles and syringes.

4) Focus on high-risk *behaviors* rather than high-risk *groups*, strongly conveying the fact that anyone can become infected with HIV regardless of age, sex, race or sexual orientation.

5) Provide an ample number of sessions to provide multiple opportunities to discuss new information and relate it to personal decision-making — a single class period or session is not sufficient.

The knowledge needed to avoid HIV infection is basic. The facts indicate teenagers can and do understand and comprehend HIV prevention information. But this information, in order to be acted upon, should be repeated and reinforced by numerous mediums and through various avenues.

V. Delivering the Message

Guiding young people to develop behaviors to avoid HIV infection is likely to be challenging both professionally and personally. Like teenage pregnancy and drug abuse, the HIV epidemic is a complex social problem. Simply providing young people with facts is not enough. Delivering the prevention message in such a way that it will be heard requires giving teenagers the opportunity to clarify their values, practice decision-making and communication skills, and learn to resist pressure. This can best be done through programs that:

- concentrate on changing normative behavior and environment,
- are part of comprehensive health and sexuality education,
- carefully select and train leaders,
- involve teens in design and implementation,
- include people with AIDS/HIV infection as educators, and
- screen materials carefully.

Information and Approach

Programs for adolescents should concentrate on changing the normative behavior and environment. Prevention programs that teach "just say no" offer advice that conflicts with the talk on the streets and in the halls and locker rooms of schools where youth learn that "everybody is doing it." Faced with this contradiction, teens often practice "cognitive repression:" they accept only one message and act on that which they perceive will make them more socially acceptable. Thus, HIV programs that try to alter the peer culture and the environment related to sex and drugs are likely to be more successful than programs that focus only on the individual.

Teenagers vary. It is important to acknowledge the wide range of sexual experiences in a classroom or group of young people. In a typical group some teens already will have had heterosexual experiences; some teens will have had homosexual experiences; some will have had both. Some teenagers will have had intercourse; some will never have kissed anyone. Some will be dating; others may not yet be interested. Some teens may have good reasons to believe that they have been exposed to HIV; others may believe they have contracted it from a drinking fountain. Some teens may have been sexually abused or raped. Teens may have friends or relatives with AIDS; some will have parents whose behavior may place them at risk. Leaders should be aware and be prepared to acknowledge that such differences very likely exist within their target population.

It is important for the leader or teacher to address all of the young people in any general setting. In order to assure that all members of an audience feel included, use language that is as inclusive as possible. Generic references to "one's partner" and avoidance of "he/she" pronouns can help accomplish this. Information which addresses and acknowledges differences in relationships and sexual orientations in a positive tone is also inclusive. Materials and educational approaches which disregard variations in experiences serve to further isolate an already isolated population of gay and lesbian youth, who are notably vulnerable to HIV infection. Leaders may encounter homophobic comments. The HIV epidemic has led to a rise in incidents of violence against homosexuals and has the potential of increasing homophobia among teens. Since some of the young people in any program may be gay or lesbian and unsure of their sexual orientation, leaders can serve as resources by providing nonjudgmental counseling or making appropriate referrals depending on their training and skills.

HIV education programs should be careful not to convey a scare message such as: "Sex is something that kills you." Rather, sexuality should be presented as a positive aspect of life. Prevention information should feature positive messages and should focus on reducing fear. Young people need to understand their risk of becoming infected with HIV, the consequences of HIV infection, and the role that substance use and abuse plays

Strategies & Specifics

Saying it right . . .

Correct and precise language is needed to present HIV information accurately. As in all sexuality education programs, educators can use correct language while acknowledging youth's use of slang. The leader should encourage youth to communicate using whatever language they know. When a slang term is used the leader can check out its meaning and supply the "correct term." One helpful exercise for new groups is for leaders to ask teens what words they know for such terms as "penis," "vagina," "oral sex," "masturbation," etc. With this exercise the leader can acknowledge the discomfort created when talking about certain subjects and also help to define such terms for youths who may not know correct terminology and are afraid to ask. Once a common language has been established, leaders should request that participants use "correct terms" during the sessions to avoid further misunderstanding.

Strategies & Specifics

Speaking of Condoms . . .

There are many creative ideas for encouraging effective condom use among sexually active teens. For example:

- ☐ Activities that Explore Teen Attitudes: Teens often have very negative attitudes about condoms. Ask teens what they have heard about condoms and try to counter myths.
- ☐ Homework Assignments: Leaders can develop an optional assignment for teens to purchase a packet of condoms. This helps students develop the skills for now or the future to purchase personal products at a pharmacy. Leaders collect all the condoms purchased, and place them in an accessible place. Leaders can ask the students to describe their experiences purchasing the condoms and identify where they were obtained. Or, teens can be asked to conduct an interview on knowledge and attitudes about HIV with a family member, thus encouraging teens to talk with their family members about HIV infection and AIDS.
- ☐ Role-playing: When used effectively, role-playing can increase teens' communication skills and enable them to rehearse ways to begin conversations about using condoms and reducing risk. Girls can practice assertiveness skills by responding to partners who say, "But it's like taking a shower with a raincoat on." Boys can practice responding to partners who say, "But I'm on the pill," or "Do you have a disease or something?"

as a co-factor in behaviors that place people at risk for HIV infection. Teens should be encouraged to respond with compassion to people with AIDS/HIV infection. And, most important, youth need to know there are many behavior options that are healthy, fun and pleasurable and that do not expose them to HIV infection.

Many young people are afraid of HIV infection and people with AIDS/HIV infection, and that fear alone may keep them from protecting themselves. Leaders can reduce this fear by explaining that HIV infection can be prevented. Teens can feel empowered by learning that they have the ability to practice behaviors that will prevent them from ever becoming infected.

The teens most vulnerable to HIV infection are those who have unprotected sexual intercourse and/or use IV drugs. Accidental infection is very rare. Often these behaviors are linked to other problems such as teen pregnancy, use and abuse of non-IV drugs, school dropout, dysfunctional families and runaways. This linkage is not, however, causative. A school dropout is in danger of HIV infection only because school dropouts are more likely to be sexually active or to abuse drugs than are young people who remain in school. The distinction is important to understanding and preventing HIV infection. If young people learn that HIV is linked to specific *behaviors* rather than to problem areas or risk groups, they can learn to avoid the behaviors that place them at risk.

When discussing sexual transmission, young people need specific information about which "fluids" transmit HIV and about behaviors that place them at increased risk for HIV infection. Phrases such as, "body fluids transmit HIV during intimate sexual contact" confuse more than they educate. Specific references to blood, semen, vaginal secretions and mother's milk will get the message across.

Leaders should discuss "people with AIDS or HIV infection" rather than "AIDS victims," or "innocent victims." Such terms are judgmental and tend to shut down communication. The term "AIDS victim" may imply that all people with AIDS or HIV infection are sick, under medical care, and not successfully coping with their disease. "Innocent victim" implies that certain people deserved to contract the disease and others did not. Many people with AIDS or HIV infection are without symptoms of disease and lead productive lives. People with AIDS or HIV infection are valuable resources in a community's response to the HIV epidemic.

Reducing the Risk

One of the more difficult and important tasks for leaders is to discuss risk reduction guidelines with teens and to inform teenagers about the specific sexual behaviors that place them at risk for HIV infection. Because most teenagers experiment with some types of sexual behavior, educators can help teens understand which ones are safe and which ones are risky.

Strategies to encourage abstinence are an important component of HIV prevention. Young people need to learn to express affection through non-genital activities and non-sexual avenues and to learn that engaging in intercourse is not the only means to give or receive pleasure. Abstinence from any type of sexual intercourse — oral, vaginal, anal — is safe.

There are some sexual activities that are truly safe, i.e., they do not transmit HIV. Teenagers need to receive information about alternatives to sexual intercourse. There are a variety of behaviors that can be discussed such as talking, kissing, dancing, hugging, holding hands, massaging, masturbating, and sexual pleasuring in the context of showing and receiving affection that do not include intercourse.

It is important that programs provide an environment that enables youth to express themselves, and permits them to learn about their sexuality. Many programs, for example, allow discussion of sexual intercourse — yet preclude discussion of masturbation. Too frequently HIV prevention programs focus only on "saying no" or using condoms. A 17-year-old CPO conference participant summed it up like this: "Our society seems to have

More on Condoms...

- ☐ Condom Couplet Contest: Ask participants to develop two line rhymes or raps promoting condom use for sexually active teens and promoting abstinence or the delay of intercourse.
- ☐ Encouraging Teens to Carry One for a Friend: The leading reason teens give for not using a contraceptive method is that they don't expect to have intercourse. Educators should promote the attitude that it is not "OK" to have intercourse without a condom. If teenagers routinely carried condoms, they would be prepared for situations when "sex just happens." Teens could also provide a condom for a friend who might otherwise engage in risky behavior.

an idea that kids should not know about sex, because they might think about it — even try it!"

Educators should be realistic about the number of teens in their programs who are having sexual intercourse. In a typical group of 16-year-olds, half are likely to be engaging in intercourse, half not. Those young people who are engaging in risky sexual behaviors need explicit information about how to reduce their risk. Leaders can help them to understand both the risk they're taking and the need to reduce it.

Assessing risk is easier said than done. It is difficult because many people, teenagers and adults, do not know whether they have been or will be exposed to the virus. Advising teens to "Know someone well" or "Ask your partner about AIDS" is an unrealistic way to evaluate potential risk. Teenagers cannot know — nor can adults — if someone is infected either by looking at them or through intuitive powers. Even an honest discussion is inadequate because potential partners may not know that they have been exposed to HIV.

Use of condoms during intercourse with an infected partner or a partner whose antibody status is unknown is not without risk; rather, it can only be considered less risky. Condoms have proven to be an effective barrier to HIV in the laboratory.(26) However, condoms can break or leak, especially when they are not used correctly. Although condoms are not 100 percent effective against the spread of HIV or for preventing pregnancy, they offer the *best protection available* for people who are going to have intercourse with a partner whose antibody status is unknown.(27) Many of the problems associated with condoms have to do with incorrect use. Explicit instructions are essential if risk is to be reduced. Such education is best if it also includes a focus on values and behavior. In addition, it does little good to tell teens to use condoms if they do not know where to get them. Helping teens to survey drugstores and convenience stores is one way to increase their awareness of condom availability in the community.

■ RIGHTS	■ RESPONSIBILITIES
To have correct information.	To ask questions when you don't understand.
To say "no" to sex or "wait".	Not to pressure anyone to have sex.
To become a parent only when ready.	To say "no" or "wait" to have intercourse if you're not ready.
To have access to condoms and other birth control methods.	To use a condom and other birth control methods.
To remain free of sexually transmitted diseases.	Not to have intercourse if you have a sexually transmitted disease.

Teenagers should be helped to understand that they have rights and responsibilities regarding sexual behavior. These rights include the right to accurate information, the right to say "no" or "wait" to have intercourse, the right not to become parents before they are ready, and the right to be protected from sexually transmitted diseases, including HIV. It is often more effective to talk with young people about their rights, rather than responsibilities.

HIV education programs should encourage teens not to experiment with drugs, including alcohol, because drugs and alcohol may impair their ability to make good decisions about sex. Teens need to understand that sharing needles and syringes for any reason — including ear piercing, tattooing, taking steroids and other injected substances — puts them at risk. Even sharing other blood-contaminated items such as razors may be means by which minute particles of blood are passed from one person to another. Since drug use is widespread, all teens need information about sterilizing drug equipment including needles, syringes, cookers and cotton in combination with information on community drug treatment centers, so they can help themselves or a peer.

In youth development programs, HIV information can be incorporated into programs on peer pressure, dating, self-esteem, employment, communication skills, and substance abuse prevention.

Integration of Prevention Messages

HIV education should, ideally, be part of a comprehensive health or sexuality education program at all ages. A comprehensive health, family life or sexuality education program should include decision-making, goal-setting, values exploration, and discussion of sex and gender roles, as well as factual information about reproduction, physiology, contraception, and sexually transmitted diseases. Effective programs frame the discussion of the disease in the broader context of human sexuality and health promotion.

Program coordinators should analyze the potential vehicles for integrating HIV education messages into programs that already exist. The analysis should also review the nature and background of existing health and sexuality education programs, the amount of time available to explore the exercises relevant to HIV prevention goals and objectives, and the financial resources needed to implement new program components.

In youth development programs, HIV information can be incorporated into programs on peer pressure, dating, self-esteem, employment, communication skills, and substance abuse prevention. In schools, HIV information can be integrated into many subject areas, for example: Social Studies — civil rights and the HIV epidemic; History — the history of epidemics; Biology — medical aspects of HIV; Home Economics — food preparation and handling; Drama/Theater — performances about the personal side of HIV; Math — statistics and word problems.

Community service agencies that provide health and sexuality education can easily integrate basic HIV information along with exercises to help youth develop the behaviors they need to avoid HIV infection.

Choosing and Training Effective Leaders

Leaders are the most important variables in a program's success, so appropriate selection and training is crucial. Individuals selected must place a high priority on HIV prevention programs, and they must also have or be able to obtain the support of youth, parents, and other members of the community.

Leaders will have their own beliefs and values about many of the concerns raised by the HIV epidemic, and may be more or less comfortable with some of the issues that youth are likely to raise. In particular, leaders may feel uncomfortable presenting information on certain sexual topics or drug use. Teachers and group leaders should be well trained in human sexuality and in drug abuse and have the skills to teach about HIV sensitively. Training should include exploration and clarification of their own values about sexuality and drug use to enable them to teach without imposing their personal judgments on youth.

Strategies & Specifics

How to use a condom . . .

Leaders can include explicit instructions about condom use, or may want to adapt these instructions as a participant handout.

Condom Instructions

- ☐ Use latex (it's on the label) spermicidal condoms or use latex condoms with contraceptive foam. All condoms offer protection against pregnancy; used with foam, condoms are more effective. Latex are the best to protect against sexually transmitted diseases and Human Immunodeficiency Virus (HIV) — the virus that causes AIDS.
- ☐ Use a new condom every time you have sex (intercourse) — no matter what type of intercourse you are having.
- ☐ Unroll the condom onto the erect penis before the penis comes in contact with the mouth, vagina, or rectum.
- ☐ Hold the tip of the condom to squeeze out the air. This leaves some room for the semen when the man comes (ejaculates).
- ☐ After the male comes (ejaculates) and while the penis is still erect, he should pull out. Hold onto the rim of the condom while pulling out, so the semen does not spill out.
- ☐ Keep condoms away from heat, as heat will dissolve the latex (rubber). Use contraceptive foam or water-based jellies (such as K-Y jelly) for added wetness (lubrication), but never use oil-based jellies (such as vaseline) because the oil will destroy the latex.

In most cases, an on-going leader or teacher is preferable to an outside "expert." Most youth group leaders, drug abuse counselors, church leaders and physical education teachers can be trained to provide HIV education. Effective leaders demonstrate the following:

- the belief that HIV education is important and behavior development is possible,
- willingness and interest in teaching HIV prevention and education,
- genuine appreciation and respect for adolescents and for people with AIDS/HIV infection,
- basic knowledge about HIV, its transmission and its prevention,
- familiarity and comfort with sexual terminology and sexual issues,
- knowledge about and familiarity with drug use and terminology,
- respect and support for a diversity of student and family values, and
- effective communication and teaching skills.

Teen Involvement in HIV Education

When it comes to changing attitudes and communicating a message, peer pressure works best. Peer pressure can be positive as well as negative. Facts about HIV are facts, and educators can provide facts. But teens can package the message best. Teenagers are the essential component of the community to include in developing behavioral norms to prevent HIV infection among their peers.

The most successful health education interventions with teenagers are those coordinated by teenagers themselves with the goal of changing teenage behavioral norms. (28) Increasingly, youth workers are discovering the value of shaping the energy and talents of peer educators. There are additional benefits in fostering peer-mediated education:

1) Adult support for such education validates the importance and influence of peer exchange.

2) The environment of a school or community setting is altered so that messages conveyed to teens about sexual behavior and drug use are more consistent.

3) Teens recognize that they have an active and essential role to play in teaching, in learning, and in protecting themselves rather than being passive receivers of education.

There are hundreds of peer education and counseling groups for teens that deal with issues of sexuality and/or drug use. Groups like these can be prepared to handle the issue of the HIV epidemic, and can serve as a model for HIV-specific peer programs. There are growing numbers of exciting teen HIV-prevention projects in place around the country. For example:

The Good Samaritan Project "Teen TAP" in Kansas City, Missouri. Participants staff a national "800" hotline to provide HIV information for youth, give presentations to community youth, and assist adult volunteers in making presentations to youth-serving professionals.

Goshen High School, Goshen, Indiana. Students are conducting a needs assessment for sexuality and HIV education, and surveying current knowledge levels among children of all ages throughout the school system. They will present the results of their research to the school board in an effort to encourage the board to mandate HIV education.

The Center for Population Options' pilot program Teens for AIDS Prevention (TAP) in six pilot-sites across the country. TAP groups in each community will be implementing a variety of activities to reach the youth with HIV prevention messages. Activities include: skits; "rap" music compositions; assemblies; posters, advertisements, buttons, pamphlet and sticker design and distribution; an information bulletin board; and informal discussion groups.

Strategies & Specifics

Teens can...

- ☐ serve as role models for other teens,
- ☐ educate each other,
- ☐ act as peer counselors,
- ☐ design materials,
- ☐ produce videos and PSA's,
- ☐ write newsletter articles,
- ☐ serve on advisory boards,
- ☐ conduct needs assessments,
- ☐ organize student HIV prevention and education groups,
- ☐ volunteer at community-based AIDS organizations,
- ☐ design and conduct innovative projects, and
- ☐ advocate for themselves.

Involvement of People with AIDS/HIV Infection

Young people with AIDS/HIV infection can be educators themselves and present an invaluable resource to other educators. Many youth are afraid of HIV infection and of people with AIDS/HIV infection, and that fear alone may keep them from protecting themselves. Teens are concrete thinkers and personalizing HIV infection will help students deal with fears and misconceptions. Teens need to understand that HIV infection is almost always fatal, with no known cure. People with AIDS/HIV infection can dramatically portray the reality of living with AIDS/HIV infection, helping to break through the teenager's wall of invincibility and denial.

When teens meet a person with AIDS/HIV infection, they realize that the person looks a lot like them, talks like them and likes to do some of the same things they do. Infection with HIV becomes real and personalized. The remarks of one 16-year-old high school student, after meeting a person with AIDS as part of an education program, are typical. She said, "I had the privilege of meeting a person with AIDS and it was my first time meeting a person with AIDS so I was really — I wasn't scared but I was somewhat hostile to meeting him. And, he taught us a lot! A lot that no one could ever teach us just by saying what AIDS research says, but he has really dealt with it and I felt that — as though he was very strong and brave to come."

People with AIDS/HIV infection can provide a very powerful learning experience for youth and may be located by contacting the National Association of People with AIDS or by calling a local People with AIDS (PWA) coalition. If a PWA representative is unavailable for a presentation, movies and videos that include PWA can also be very powerful teaching tools.

Materials Selection

Educational brochures, pamphlets, videos, and curricula for adolescents abound, many of high quality. All HIV materials have a short life span because of continual discovery of new information. As the field of HIV education matures, its language and messages become more specific. Because of limited funding, it is sometimes necessary to continue using HIV education materials that are slightly out-of-date. Such materials can be used effectively as long as educators point out and discuss changes and clarifications in the information presented in the dated materials, and take advantage of the opportunity to reinforce the validity of the core HIV prevention and transmission messages, while helping adolescents understand the significance of any new information.

Carefully review materials before using them, and include adolescents from the target audience in the review process, perhaps as part of a formal review committee. Many agencies use community advisory boards to review all materials before purchasing them for educational use.

For maximum effectiveness and impact, materials should be specifically designed for a particular audience. Materials should be sensitive to the target audience with respect to age, developmental level, cultural and ethnic background, sexual orientation, prevalence of IV drug use, levels of sexual activity, school status (enrolled, graduated or dropped out) literacy levels and employment status.

Language and illustrations should reflect community values and needs without compromising the effectiveness of the prevention message. Information must be presented frankly and explicitly in words and images youth can relate to and understand. Involvement of adolescents from the target audience in the review process will greatly enhance the selection of effective materials.

To help determine the reading level of printed materials, there are many easy to use readability formulas such as McLaughlin's "SMOG Readability Formula," the "Fry Readability Graph" and the "Gunning Fog Index." These formulas, along with information on readability formula software for computers, are available at public libraries.

To determine whether information is accurate and current it may be compared with reports affirmed by the U.S. Department of Health and Human Services, Centers for Disease Control (CDC), Some of the most authoritative sources are the "Morbidity and Mortality Weekly Report" (MMWR), the *Surgeon General's Report on Acquired Immune Deficiency Syndrome* and the CDC's National AIDS Information Clearinghouse. (See below) Also, the National AIDS Hotline is available 24 hours a day at 1-800-342-AIDS, Spanish access 1-800-344-SIDA, and hearing-impaired access 1-800-AIDS-TTY.

There are a number of informational pamphlets on HIV prevention and education for the general public. Two excellent examples are the *Surgeon General's Report on Acquired Immune Deficiency Syndrome* and *Understanding AIDS* the booklet mailed by the U.S. Department of Health and Human Services to every household in America. For further information on these and other resources available from the U.S. Government, contact the National AIDS Information Clearinghouse at 1- 800-458-5231.

No single pamphlet or video is a complete HIV education program. HIV prevention and education materials serve best as part of comprehensive health promotion programs for youth. Many of the audiovisuals and pamphlets are excellent tools to trigger discussion of complex and powerful information or to provide reinforcement for information previously discussed. Materials that encourage open and thorough examination of teens' personal questions, concerns, and fears in both public and private forums will be most effective in helping adolescents develop the behaviors necessary to avoid HIV infection.

VI. HIV Education: A Shared Community Responsibility

Strategies & Specifics

Counseling youth . . .

Health clinics should develop guidelines for counseling young men and women whose behaviors put them at risk for HIV. Such guidelines should include, at a minimum, the following:

- ☐ All teen clients seeking contraceptive services should be counseled about the risk of HIV infection.
- ☐ Each individual client's risk of sexually transmitted diseases and HIV should be assessed.
- ☐ Additional personal data questions can be added to the history or intake form to help assess clients' risk.
- ☐ Clients whose behavior places them at risk for HIV infection should be encouraged to use condoms.
- ☐ Clinics should negotiate referral mechanisms with anonymous HIV testing sites.
- ☐ All clients who have sexual intercourse, male and female, should, at a minimum, receive condoms and instruction sheets. Clinics are also logical sites for massive condom distribution campaigns. They can encourage clients to take several packages of condoms and instruction sheets, both for their own use and to pass on to their friends.

The HIV epidemic poses an unprecedented threat to the future of today's and tomorrow's adolescents and an unprecedented challenge to the agencies and institutions that serve them. Concerted, community-based campaigns are urgently needed to guide the nation's youth in developing behaviors which reduce risk of HIV infection. The delivery of HIV prevention and education must stretch beyond conventional boundaries and combine unusual resources: the classroom, the street, the living room and the playing field; teachers, parents, medical and youth-serving professionals, media, people with AIDS/HIV infection, and youth themselves. Parents/family, schools, school-based clinics, churches and synagogues, youth-serving agencies, community health and service centers, businesses and civic groups, and community-based AIDS organizations must all join together if a community is to provide an extensive net of care targeted to both in-school and out-of-school youth. By identifying a united message and assigning responsibilities throughout the community, HIV prevention and education can be integrated into every organization's mission, with the reward being an improved flow of correct information and broader delivery of unduplicated services to youth.

Coordinated Community Efforts

HIV prevention and education can be accomplished effectively through the cooperation of many sectors of the community. Coordinated efforts, in the long run, will provide more information and additional services to youth, attract more financial resources, allow more accurate data collection on the youth who are being served, and help build the foundation for services required by adolescents.

One excellent model is the Coordinating Council for Youth Services in the Los Angeles County area, a prime example of a broad-based community coalition. This coalition, which grew out of a high-risk youth project developed by the Division of Adolescent Medicine at Children's Hospital of Los Angeles with the L. A. Free Clinic seeks to provide comprehensive health care, case management, health education, and confidential services to adolescents. The council includes members of the Board of Education, Gay and Lesbian Community Service Center, Los Angeles Police Department, Public Health Department, City Hall, YMCA, Department of Mental Health, religious organizations, homeless and runaway shelters, family planning clinics, Job Corps, The Salvation Army, foundations, training centers, high schools, health maintenance organizations, hospitals, entertainment media, and many more.

Several other communities have successfully mounted concerted and ongoing community-based campaigns to prevent adolescent drug abuse and to reduce adolescent pregnancy. Two particular examples were recently published in the *Journal of the American Medical Association.*

1) The entire early adolescent population of the 15 communities that constitute the Kansas City (Kansas and Missouri) metropolitan area has participated in a community-based program for prevention of drug abuse since September 1984. The Kansas City area is the first of two major metropolitan sites being evaluated in the Midwestern Prevention Project, a longitudinal trial for primary prevention of cigarette, alcohol, and marijuana use in adolescents. The project includes mass media programming, a school-based educational program for youth, parent education and organization, community organization, and health policy components that are introduced sequentially into the communities during a six-year period. Effects of the program are determined through annual assessments of adolescents' drug use in schools that are assigned to immediate intervention or delayed intervention control conditions. In the first two years of the project, 22,500 sixth-and seventh-grade adolescents received the school-based education program component, with parental involvement in homework and mass media coverage. Analyses of 42 schools indicate the prevalence rates of use for all three drugs are significantly lower at 1-year follow-up in the intervention condition relative to the delayed intervention con-

dition, with or without controlling for race, grade, socioeconomic status, and urbanicity, and the net increase in drug use prevalence among intervention schools is half that of delayed intervention schools. (28)

2) The resident population of the western portion of a South Carolina county has undergone a public health information and education intervention since October 1982. The purpose of the intervention has been to reduce the occurrence of unintended pregnancies among unmarried adolescents. Intervention messages are targeted at parents, teachers, ministers and representatives of churches, community leaders, and children enrolled in the public school system. The messages emphasize development of decision-making and communication skills, self-esteem enhancement, and understanding human reproductive anatomy, physiology, and contraception. The estimated rate of pregnancy for females aged 14 to 17 years in the county's western portion has declined remarkably since the intervention began, and the changes are statistically significant when compared with three sociodemographically similar counties and also with the eastern portion of the county. (29)

These examples indicate that effective prevention programs and service delivery for a community's young people will require coordinated, sustained effort and long-term commitment. Additionally, they represent the dedication of individuals and a community response to improving the lives of adolescents.

Characteristics of Effective Community Coalitions

An effective community coalition builds on the strengths of each of its members. The combination of organizational strengths provides the optimal "net" of services and resources, while avoiding costly, wasteful, and unnecessary duplication. A community coalition should strive for diversity to assure broad support and a full range of services to facilitate reaching the broadest possible population of youth. In the long run, coordinated community efforts provide more information and more services to youth than single-focus programs.

Coordinated community efforts benefit the participating agencies. Member organizations have an opportunity to advocate for their programs with a stronger voice. Meetings provide the opportunity to highlight programs, to share resources, to identify opportunities for referral, to bring in guest speakers and to conduct in-service trainings. Networking becomes a kind of "mutual technical assistance" which enables participating agencies to pool resources and expertise. And, the juxtaposition of agencies not normally in contact with one another results in all having a more complete picture of needs, resources and programs for the benefit of all groups.

Coalitions provide the opportunity to build a foundation for the work being conducted in the region. Data collected on the youth being served and the measurable impact of programs and services can be shared and is invaluable in advocacy for programs and funding. A concerted effort creates a better data bank, strengthens all knowledge and provides a more significant basis for program evaluation.

Coalitions are able to fund more comprehensive services to youth. Foundations and government agencies seek well-coordinated community efforts to fund. Since competition among agencies is often cited as the most significant obstacle to efficient and effective delivery of programs and services to youth, proposal development can be one of the joint activities undertaken by the coalition as a whole. Proposals can be developed by professional writers from agencies with such staffing capabilities while other organizations in the coalition can be contracted with to deliver specific services.

Each coalition has its own structure. Some charge a nominal membership fee or require formal consent from the executive director of the organization being represented. All coalitions should have an explicit, formulated purpose to allow represented organizations to respond with a united voice. Presenting a unified and united front is essential.

Broad-based coalitions can speak authoritatively for a broad spectrum of the community. This authority comes to the fore and can be molded by the coalition in a variety of ways to stimulate and cement community support. Coalitions can articulate the reasons that HIV prevention programs and services are so important. They can have diverse segments of the community lined up for support in various public and policy-making forums. They can develop position papers outlining program goals and philosophy. The local media (newspapers, radio, and TV) will disseminate correct information if coalitions will offer briefings and seminars for media leaders and host community forums. These public efforts, in turn, help the majority of people, who support HIV prevention programs and services, to speak up.

Coalitions should anticipate some opposition and be prepared to respond to controversy. Opposition may come from small *ad hoc* groups that have a history of opposing other initiatives, such as against sexuality education. The threats loom large because the opposition is often highly organized and vocal. A coalition can articulate the reasons that make HIV prevention so important and will have the support of diverse segments of the community. A fast, coordinated response to criticism of the coalition's work can keep the opposition from blocking programming.

Every teenager has the right to know the facts about HIV prevention and the services available to him/her.

Community-wide Responsibilities

Communities have a responsibility to their youth and to the community's future to effectively prevent the further spread of HIV. Parents/family, schools, school-based clinics, churches and synagogues, youth-serving agencies, community health and service providers, businesses and civic groups, and community-based AIDS organizations must all join together. The whole community needs to know the facts about HIV, to know why teens are at risk for HIV infection and how to support teens who are already infected with the virus. Preventing the further spread of HIV among teenagers requires creating unified educational programs, ensuring access to services and expanding their availability, and encouraging discussion and questioning. Every teenager has the right to know the facts about HIV prevention and the services available to him/her. Adolescents are forming lifetime health habits and need guidance and role models to develop their adult health and sexual behaviors. It is the community members' responsibility to youth to present them with all the facts. To do otherwise is to do young people a disservice, one that could deny them information that could save their lives.

Parents/Family

HIV prevention and education programs for families must continue to be developed. Families are the primary sexuality educators of their children. From birth, parents communicate about sexuality by the way they touch and hold their children, by the words they use for body parts, and by the way they treat their children according to gender. Children form the foundation of their own values and behaviors by observing how adults within their family communicate, display affection, and express opinions.

Families need and want help with information and programs. Most parents agree that it is their responsibility to provide sexuality education to their children, yet few actually offer adequate factual information.(30) Only one-quarter of adults say that they learned about sexual intercourse from their mother or father.(30) More than eight out of ten parents say they would like help in providing sexuality education to their children.(31) Sexuality education programs for parents are important for HIV prevention. One study shows that when sexuality is discussed in the home, teenagers are more likely to delay sexual activity, and more likely to use contraception when they do become sexually

active.(32) Parent/child sexuality education courses can effectively increase communication about sex in the home.(33) Excellent programs on parent/child communication have been developed by the National PTA and the San Francisco AIDS Foundation. These programs include HIV information for parents and provide successful mechanisms for delivering needed information to young people.

Schools

With their potential for reaching 95 percent of the nation's young people, the schools are an optimal setting for HIV education. HIV prevention and education in the classroom should be required for all school-age children. The most effective programs do not deal with HIV in isolation, but, rather, integrate the topic into comprehensive health, family life or sexuality education programs that go beyond biology to incorporate decision-making and communication skills.

Several membership organizations that are affiliated with school systems advocate a comprehensive approach to HIV prevention and education. These national organizations, several of which hold cooperative agreements with the U.S. Centers for Disease Control (CDC) to prevent the spread of HIV through comprehensive school health education, include: the American Association for Health, Physical Education, Recreation and Dance, American Association of School Administrators, American Federation of Teachers, American School Health Association, Council for Chief State School Officers, National Association of State Boards of Education, National Education Association, National Rural and Small Schools Consortium and the National School Boards Association. In addition to these CDC-funded organizations, the National Safety Council has developed a guide for school and local administrators. These organizations have developed a framework for local discussion on HIV education for school-age youth and should be contacted for additional information.

As important as school programs are, it would be unrealistic to expect that such programs alone will alter young people's behaviors. Evaluations of sexuality education programs have found that they are very effective in increasing knowledge — a necessary but insufficient step toward behavior change. A national study of sexuality education found that unless classroom education is combined with provision of actual services, there is little likelihood that sexual behaviors will be affected.(34)

School-based clinics offer an unusual opportunity to combine education with health services on a school campus. As of January 1989, there were 150 clinics in 29 states, providing comprehensive health care for adolescents. Over half the students who use the clinics have no other source of primary health care. Often the proportion is higher, in some clinics approaching 100 percent. Nearly 90 percent of the clinics offer diagnosis and treatment for sexually transmitted diseases for both males and females; 85 percent provide gynecological exams and about 61 percent refer for birth control methods and examinations. Health services are usually integrated with mental health counseling and health education.(35)

School-based clinics in San Francisco and New York City provide HIV prevention and education programs as part of clinic services. All students who come to these clinics receive information about HIV, and if they are sexually active, counselors discuss condoms with them. The counselors also give presentations in health education classes. The clinics do not, however, provide HIV testing services. Schools with clinics can coordinate HIV instruction and counseling with reproductive health counseling where appropriate. The result is a true "net" of services adaptable to young people's varying needs.

Religious Organizations

Churches and synagogues are potentially important locations for HIV prevention and education for young people, as well as for parents and children together. These settings can place messages about sexual activity and relationships in the context of religious values. For many religious organizations, the development of comprehensive health, family life or sexuality education programs for teenagers is part of a broader emphasis on social concerns.

An advantage to conducting HIV prevention and education activities in religious institutions involves their ability to discuss values about sexuality in a manner that is not possible in public school-based education. Churches and synagogues strongly influence community ethical standards, and many individuals turn to their religious institutions for guidance and counseling on difficult issues. While many religious institutions have made significant contributions to promoting compassion and providing services for people with AIDS/HIV infection, some continue to erect barriers to information on effective prevention and education messages.

Youth-serving agencies that offer multiple services concerned with the overall well-being of youth are also well positioned to integrate HIV education into their comprehensive programs.

Recently, the National Council of Churches of Christ in the U.S.A. developed an *AIDS Bibliography* with selected resources for church educators. The National Council also has gathered together church statements on AIDS. Statements are included from the General Convention of the Episcopal Church; The American Friends Service Committee; The General Board of Global Ministries, United Methodist Church; Presbyterian General Assembly; United States Catholic Conference; American Lutheran Church; United Church of Christ; and the American Baptist Churches.

Local churches and synagogues can involve themselves both directly and indirectly. Church groups can provide assistance to people with AIDS/HIV infection. Clergy can become members of local boards of HIV prevention projects. Churches can make space available for and participate in meetings of community coalitions. HIV education can be incorporated into religious programs for families such as marriage seminars, youth groups, parent-child programs, and weekend family retreats. At these programs, the religious groups work with families to develop children's attitudes toward healthy sexuality and toward a sense of compassion for others.

Youth-serving Agencies

Youth-serving agencies (YSAs) that offer multiple services concerned with the overall well-being of youth are also well positioned to integrate HIV education into their comprehensive programs. These community agencies offer young people a variety of social, educational, and recreational programs. Together with the youth programs of major religious organizations, they serve an estimated 20 million youth each year. Of the youth served by YSAs significant numbers are pre-adolescents, homeless, and out-of-school youth — three groups, often underserved, that urgently need HIV prevention information.

Many national YSAs have developed sexuality education programs for their affiliates with goals that range from preventing adolescent pregnancy, to reducing the risk of HIV infection among youth, to delaying sexual intercourse. The programs vary both in length and in the amount of information they provide. Organizations with such programs include: American Red Cross, American Home Economics Association, Boys Clubs of America, Girls Clubs of America, Girl Scouts of America, March of Dimes, National Network of Runaway and Youth Services, National PTA, and YWCA of the U.S.A. These national organizations have established formal policy statements that support sexuality education and/or HIV prevention, and express the organization's position on the issues as well as its commitment to develop and support programs relating to those issues.

Youth-serving agencies can be effective providers of sexuality-related education. Local YSAs have reported that implementing such programs has made their overall

Strategies & Specifics

Keys to effective condom distribution...

- ☐ Offer a variety of latex condoms, lubricated, dry, or reservoir tip. Let clients know they have a choice.
- ☐ Display condoms creatively and attractively. Place them where clients can easily pick them up without asking.
- ☐ Make large numbers of condoms available to clients, not just three or four.
- ☐ At check-out, ask clients if they would like some condoms for themselves or a friend.
- ☐ Incorporate partners in education sessions.
- ☐ Make sure your clinic is a welcoming environment for young people and that its hours are appropriate for teens. Display and make available pamphlets, magazines and posters directed toward youth.
- ☐ Make sure that posters and pamphlets are easy to read, culturally appropriate, and sensitive to the client population.

program more relevant to teenagers, increased youth involvement in agency programs, increased parent involvement — and accomplished their objectives without community or parental opposition.(36) Local YSAs need not create separate HIV prevention and education programs; this information can be incorporated into the variety of other programs targeted to teens. These might include health, fitness, safety, or life options programs, as well as sexuality education programs.

Community Health and Service Centers

Community health and service centers are central to HIV prevention and education among teenagers. Family planning clinics and health departments are ideally positioned to provide education to sexually active teens. Community health centers, public health clinics, drug addiction programs, and local youth shelters serve large numbers of preadolescents and teenagers. These programs have the ability to reach large numbers of young people who have dropped out of school or are resistant to the educational system.

Health care providers have a responsibility to offer information on HIV prevention, education, counseling and, if needed, to refer to other community agencies any client who may be sexually active. Medical professionals — physicians, nurses, counselors, and clinic educators — should receive specific training about HIV and the developmental stages of adolescence ideally including basic information about the virus, guidelines for risk reduction, information about HIV testing sites and community resources. They must be willing to discuss sex, drugs and HIV infection with their young patients. Their training must also prepare them to assess a client's risk level. The American Medical Association, American Association of Physicians for Human Rights, and American College of Physicians have responded to many of these issues and have position statements available. Both the Planned Parenthood Federation of America (PPFA) and the National Family Planning and Reproductive Health Association (NFPRHA) have developed guidelines on HIV for family planning clinics.

Drug treatment programs also should be more accessible and more widely available to teenagers who are using or abusing drugs. Outreach strategies are essential for teenagers who are at high risk of becoming drug users and those who are already involved with drugs. Special attention must be paid to reaching out-of-school youth and youth living on the streets.

Runaway and homeless shelters provide an opportunity for reaching many youth who are disconnected from mainstream social agencies. The National Network of Runaway and Youth Services reports that these youth have little or no access to their families, schools, or medical services. They have no communication systems that would enable them to learn about HIV and no personal resources or support networks to help them make the personal choices to protect themselves and others. Fear, anger, depression and hopelessness experienced by these youth affect the way they understand and act upon the limited HIV information they do receive. These youth often manifest multiple, grave problems including drug dependency, legal problems and medical needs and may engage in means of survival such as prostitution and drug pushing. In addition, gay male, lesbian, bisexual, and transsexual youth comprise as much as 25 percent of all youth living on the street in this country.(37) These crisis issues are likely to take precedence over, or contribute to, the denial of concerns about HIV infection. For these and many more reasons, it is crucial that shelters be linked with one another and to other community organizations responding to the HIV epidemic.

Community health and youth-service centers must play a major role in developing and carrying out a community response to preventing the further spread of HIV infection. Youth service providers should incorporate HIV prevention and education into all aspects of their programs if the goal of stopping the spread of HIV among adolescents is to be reached. In addition, public education and outreach efforts should be mounted to inform youth about how to contact and locate the centers.

Community-based AIDS Organizations

Community-based AIDS organizations have been and continue to be at the forefront of the fight against the HIV epidemic, with all-out campaigns for HIV prevention and education at local, state and national levels. To meet community needs these organizations provide HIV prevention and education services including outreach, media campaigns, telephone hotlines, speakers' bureaus, and HIV testing sites. There are programs for people with AIDS or HIV infection that include group housing, o..., tient medical and dental care, counseling and support groups, legal assistance, hospice care, food banks and buddy programs.

Nationwide, more than 750 community-based AIDS service organizations have formed in response to the HIV epidemic. Five of these organizations created the National AIDS Network (NAN), in 1985, to represent community-based AIDS care at a national level. NAN acts as both a conduit to allow service providers to share experiences and as a clearinghouse for information and programs.

In a recent study of drug and convenience stores in Washington, DC, teenagers found it difficult to find and buy condoms, and females had more negative experiences buying condoms than did males.

Many of the programs developed by community-based organizations were originally designed to serve the gay community but have since been adopted as models for providing similar services to other audiences. Community-based AIDS organizations have experience in tailoring educational messages to the sensitivities and needs of specific groups. They use explicit language and images to reduce risk among individuals engaging in high-risk behaviors such as having unprotected sexual intercourse and sharing contaminated needles. They also design specific messages to cross socioeconomic barriers and reach people from diverse ethnic, religious, cultural and sexual backgrounds.

Business and Corporate Involvement

Drug, convenience, and grocery stores — as sellers of condoms — are an important link in the community chain of HIV prevention. However, challenges are still great in this arena. For example, in a recent study of drug and convenience stores in Washington, DC, teenagers found it difficult to find and buy condoms, and females had more negative experiences buying condoms than did males.(38) Personnel, consumer relations, and marketing policies and practices have a direct impact on youths' ability to secure condoms to protect themselves from both pregnancy and HIV. These procedures should be reviewed and altered, as necessary, to make sure that teens who want to behave responsibly can do so. Store owners and managers can take these simple steps to make condoms more accessible to teens at-risk for HIV infection:

- Place signs in the aisles to mark where contraceptives are located.
- Display contraceptives where young people can buy them without having to ask for them. (Pilferage, a great concern of many retailers, can be effectively addressed by establishing the family planning section on an end aisle near a cashier.)
- Locate all family planning methods together.
- Treat young people with the same respect given to older customers.
- Provide pamphlets and other information on contraceptives and sexually transmitted diseases including HIV. (Information on HIV is available free from the National AIDS Information Clearinghouse.)

Corporate America is demonstrating its leadership in the fight against the HIV epidemic. Many companies have already created workplace policies and employee education processes for the treatment of people with AIDS/HIV infection. Programs include case management of medical issues in the context of the corporation's overall responsibility. Corporations have also joined together to create organizations such as the National Leadership Coalition on AIDS and to make contributions of money and resources to AIDS-related efforts. Many of the companies participating in these efforts are

also members of the United Way of America's National Corporate Leadership program. Corporations from this program formed a committee and jointly produced a workplace manual called *Facilitating AIDS Education*. Allstate Insurance Company, in conjunction with several other companies, produced a manual called *AIDS: Corporate America Responds*. Entire industries have contributed funds and other resources to many community-based programs supplementing national, state and local governments with the additional dollars needed to effectively respond to the HIV epidemic.

Juvenile Justice System

Youth who come in contact with juvenile detention or correctional facilities are a distinct population in need of HIV education. According to the National Commission on Correctional Health Care, the vast majority of youth in juvenile facilities come from poor or neglecting homes where their health education and quality of health care are inadequate. They are often victims of physical and sexual abuse. Typically, after incarceration of less than a year, these youth return to the streets where they are likely to engage in behaviors such as drug use and prostitution that place them at high risk for HIV infection.

Correctional facilities have access to some youth who engage in some of the riskiest behaviors for HIV infection and, thus, have the responsibility to present information on HIV prevention and education to this challenging group. The National Commission on Correctional Health Care is currently developing programs for the training of correctional and health personnel who deal specifically with youth.

Media and Entertainment Industry

The role of local news and public service programming is clear. By reporting breaking news on the HIV epidemic, the local news media helps keep people informed. The network television industry and the public broadcasting service have aired public service announcements (PSAs) and educational programs. With the support of the local broadcast community, the America Responds to AIDS PSAs (both radio and television) continue to reach thousands of Americans daily with facts about HIV. These PSAs direct HIV information to the general public and targeted audiences. The variety of spots enables station directors to choose those PSAs which best serve their communities. Information on these PSAs is available from the National AIDS Information Clearinghouse.

The entertainment media has an influential role in public education. This industry works more subtly, providing information through dramatization of the issues involved with HIV. Studies show that each week teenagers watch about 24 hours of TV (39), and spend about 30 additional hours listening to the radio or tapes and watching music videos(40). A thoughtful episode about HIV and AIDS on a popular television situation comedy or "movie of the week," can deliver educational messages in an easily digestible format. A number of television producers, writers and actors have responsibly created shows and PSAs about HIV and AIDS.

The entertainment industry needs to incorporate issues surrounding the HIV prevention message into scripts, especially those which include sexual intercourse and drug use. While individual scripts deliver accurate prevention information on HIV in an easily digestible format, they have a limited impact on attitudes and behavior development because the messages are diluted by other shows which depict unprotected intercourse or make drug use seem "cool."

The following recommendations regarding the depiction of AIDS- and HIV-related issues in the media were developed by the Entertainment Industry Coalition on AIDS as a resource to the television, motion picture and music industries. They are not, in any way, meant to limit the creative process.

- Recognize sex as a healthy and natural part of life requiring responsibility to oneself and one's partner.
- Encourage parent-child and peer conversations about sex which include information about preventing sexually transmitted diseases, including AIDS.
- Recognize and respect abstinence.
- Acknowledge that all segments of society are at potential risk of HIV infection, including teens and young adults.
- Emphasize that there is no evidence that HIV is transmitted through casual contact, but only through the exchange of blood, semen, vaginal fluids, mother's milk and during pregnancy.
- Show people with AIDS/HIV infection the sensitivity and respect accorded people with other diseases.
- Depict casual sex only if it is important to the story.
- Indicate consequences of unprotected sex.
- Include discussion of safer sex and condom use in appropriate scenes.
- Indicate consequences of shared needles in scenes involving IV drug use, tattooing and ear piercing. Show or refer to use of new needles or proper methods of sterilizing needles.
- Recognize the complexities of HIV testing and diagnosis. Differentiate between testing positive for HIV antibodies and being diagnosed with HIV Disease and AIDS.
- Acknowledge there may be a latency period of as many as ten years between contracting and the diagnosis of AIDS.
- Bear in mind the use of alcohol and drugs can lower inhibitions and lead to unsafe practices which transmit the AIDS virus.

Entertainment industry professionals have a unique opportunity to influence public attitudes, values, and behavior regarding the HIV epidemic and can contribute to preventing its further spread among adolescents.

Messages can encourage behavior development — with time, persistence, and repetition. In the past decade declines in adolescent drug abuse and in adolescent pregnancy appear to be the result of the unusual concurrence of multiple voices speaking a single message.(28)(29) Parents, teachers, visual and print media, and coalitions of caring and concerned individuals — especially peers — stating similar views and values about these behaviors seem to have made a difference. People have responded to consistent and repetitive presentation of messages, and a reduction in risky behaviors has occurred. Our best hope for encouraging healthy and positive behavior among youth to protect them from HIV infection, substance abuse and unintended teenage pregnancy rests on the community's ability to establish common goals and act in concert on these urgent public health issues.

References

1. Centers for Disease Control, *HIV/AIDS Surveillance Report*, Atlanta, GA, August 1989.
2. Centers for Disease Control, *Morbidity and Mortality Weekly Report*, Vol. 38, No. S-4, May 12, 1989.
3. Centers for Disease Control, *AIDS Weekly Surveillance Report*, Atlanta, GA, July 25, 1988.
4. Kennedy, James T., M.D., Covenant House Study, New York, NY, October 1988.
5. American College Health Association, press release, May 22, 1989.
6. Centers for Disease Control, *Morbidity and Mortality Weekly Report*, Vol. 37, No. 44, November 11, 1988.
7. Zelnick, M. and Kantner, J.F., "Sexual Activity, Contraceptive Use, and Pregnancy Among Metropolitan-Area Teenagers: 1971-1979," *Family Planning Perspectives*, Vol. 12, No. 5, 1980.
8. Zelnick, M., Shah F., "First Intercourse Among Young Americans," *Family Planning Perspectives*, Vol. 15, No. 2, 1983.
9. Clark S.D., Zabin, L.S., Hardy, J.B., "Sex, Contraception and Parenthood: Experience and Attitudes Among Urban Black Young Men,"*Family Planning Perspectives*, Vol. 16, No. 2, 1984.
10. Henshaw, Stanly K., Kenney, Asta M., Somberg, Debra, Van Vort, Jennifer, *Teenage Pregnancy in the United States*, The Alan Guttmacher Institute, New York, 1989.
11. Centers for Disease Control, STD Statistics Division, unpublished data, August 1989.
12. Cates, Willard, "The 'Other STDs:' Do They Really Matter?" *Journal of the American Medical Association*, Vol. 259, No. 24, June 24, 1988.
13. Remafedi, Gary J., M.D., M.P.H., "Preventing the Sexual Transmission of AIDS During Adolescence," *Journal of Adolescent Health Care*, Vol. 9, No. 2, March 1988.
14. Hampton, L., Newberger, E., "The Epidemiology of Abuse in Childhood and Adolescence," *American Journal of Public Health*, Vol. 75, No. 1, January 1985.
15. U.S. Department of Health and Human Services, *Fiscal Year 1985 Study of Runaways and Youth*, Washington, DC, 1986.
16. Federal Bureau of Investigation, *Uniform Crime Report for 1988*, Washington, DC, 1989.
17. American School Health Association, Association for the Advancement of Health Education and Society for Public Health Education, National Adolescent Student Health Survey, 1987.
18. Centers for Disease Control, *Morbidity and Mortality Weekly Report*, Vol. 37, No. 47, December 2, 1988.
19. Fischer, Kurt W., Lazerson, Arlyne, *Human Development From Conception Through Adolescence*, W. H. Freeman and Company, New York, 1984.
20. Roberts, Elizabeth J., Kline, David., and Gagnon, John., *Family Life and Sexual Learning*, Vol. 1, Population Education, Inc., Cambridge, MA, 1978.
21. Louis Harris and Associates, *Public Attitudes Toward Teenage Pregnancy, Sex Education and Birth Control*, Planned Parenthood Federation of America, New York, NY, 1988.
22. National Broadcasting Corporation, Inc., *NBC News Poll Results*, New York, January 16, 1987.
23. American Association of School Administrators, Arlington, VA 1988.
24. Johnson, Robert L., M.D., "Psychodynamics of Adolescence," presentation, Center for Population Options' National Conference on Adolescents, AIDS and HIV, Los Angeles, CA., May 1989.
25. Pratt, William F., Mosher, William D., Bachrach, Christine A., Horn, Marjorie C., "Understanding U.S. Fertility," Population Reference Bureau, Inc., *Population Bulletin*, Vol. 39, No. 5, December 1984.
26. Rietmeijer, Cornelis A. M., M.D., Krebs, John W., M.S., Feorino, Paul M. Ph.D., Judson, Franklyn N. M.D., "Condoms as Physical and Chemical Barriers Against Human Immunodeficiency Virus," *Journal of the American Medical Association*, Vol. 259, No. 12, March 25, 1988.
27. United States Public Health Service, *Surgeon General's Report on Acquired Immune Deficiency Syndrome*, U.S. Department of Health and Human Services, Washington, DC, 1986.

28. Pentz, Mary Ann, Ph.D., Dwyer, James H. Ph.D., Mackinnon, David P., Ph.D., Flay, Brian R., D.Phil., Hansen, William B., Ph.D., Wang, Eric Yul, M.S., Johnson, C. Anderson, Ph.D., "A Multicommunity Trial for Primary Prevention of Adolescent Drug Abuse," *Journal of the American Medical Association*, Vol. 261, No. 22, June 9, 1989.

29. Vincent, Murry L., Ed.D., Clearie, Andrew F., M.S.P.H., Schluchter, Mark D., Ph.D., "Reducing Adolescent Pregnancy Through School and Community-Based Education," *Journal of the American Medical Association*, Vol. 257, No. 24, June 26, 1987.

30. Louis Harris and Associates, *Public Attitudes About Sex Education, Family Planning and Abortion in the United States*, Planned Parenthood Federation of America, New York, NY 1985.

31. The Alan Guttmacher Institute, *Teenage Pregnancy: The Problem That Hasn't Gone Away*, New York, NY, 1981.

32. Spanier, Q.B., "Sources of Sex Information and Parental Sexual Behavior,"*Journal of Sexual Research*, Vol. 13, 1977.

33. Kirby, Douglas, Ph.D., *Sexuality Education: An Evaluation of Programs and Their Effects, An Executive Summary*, Mathtech, Inc., Bethesda, MD, January 1984.

34. Zabin, L.S., Hirsch, M.B., and Hardy, J.B., "Adolescent Sexual Attitudes and Behavior: Are They Consistent?"*Family Planning Perspectives*, Vol. 16, No. 4, 1984.

35. Lovick, Sharon R., Support Center for School-Based Clinics, Houston, TX, telephone interview, August 1989.

36. Pacific Institute for Research and Evaluation, *Sexuality Education by Youth-Serving Agencies: An Evaluative Study of the Center for Population Options Program to Expand Sexuality Education in Cooperation with Youth-Serving Agencies*, Center for Population Options, Washington, DC, 1980.

37. United States Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, *Report of the Secretary's Task Force on Youth Suicide*, U.S. Department of Health and Human Services, Rockville, MD, 1989.

38. Center for Population Options, *Teens' Survey of Stores in the District of Columbia on Accessibility of Family Planning Methods*, 1988.

39. A.C. Nielsen Company, Inc., *1984 National Audience Demographics*, New York, NY, 1984.

40. Leming, J.S. "Rock Music and the Early Adolescent," *Youth and Society*, June 1987.

Additional Resources

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(202) 293-2886

AIDS National Interfaith Network
475 Riverside Drive, 10th Floor
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(212) 870-2100

Association for the Advancement of Health Education
American Alliance for Health, Physical Education, Recreation and Dance
1900 Association Drive
Reston, VA 22091
(703) 476-3400

American Association of Physicians for Human Rights (AAPHR)
2940 16th Street #309
San Francisco, CA 94103
(415) 255-4547

American Association of School Administrators
1801 N. Moore Street
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(703) 875-0730

American Baptist Churches
Adult and Youth Ministries
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American College Health Association
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American College of Physicians
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American Council of Life Insurance
Health Insurance Association of America
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American Federation of Teachers
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American Foundation for AIDS Research
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#1 Redskin Road
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Protection of Lesbian and Gay Youth
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(212)633-8920

Intergovernmental Health Policy Project
The George Washington University
2011 I Street, NW
Suite 200
Washington, DC 20006
(202) 872-1445

March of Dimes Birth Defects
Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

National AIDS Hotline
Information * Education * Referrals
(800) 342-AIDS
(800) 344-SIDA (Spanish Access)
(800) AID-TTY (Deaf Access)

National AIDS Information
Clearinghouse
P.O. Box 6003
Rockville, MD 20850
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(800) 458-5231

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Washington, DC 20036
(202) 429-2856
(800) 338-2437

National Association of State
Boards of Education
1012 Cameron Street
Alexandria, VA 22314
(703) 684-4000

National Coalition of Advocates
for Students
100 Boylston Street
Suite 737
Boston, MA 02116-4610
(617) 357-8507

National Coalition of Black
Lesbians and Gays
19641 W. 7 Mile Road
Detroit, MI 48129
(313) 537-0484

National Commission on Correctional Health Care
2105 North Southport
Suite 200
Chicago, IL 60614
(312) 528-0818

National Council of Churches in Christ in the U.S.A.
Division of Education and Ministry
475 Riverside Drive
New York, NY 10115-0050
(212) 870-2271

National Council of La Raza
810 First Street, NE
Suite 300
Washington, DC 20002
(202) 289-1380

National Education Association
1201 16th Street, NW
Washington, DC 20036
(202) 833-4000

National Family Planning and Reproductive Health Association (NFPRHA)
122 C Street
Suite 380
Washington, DC 20001-2109

National Gay and Lesbian Task Force (NGLTF)
1517 U Street, NW
Washington, DC 20009
(202) 332-6483

National Leadership Coalition on AIDS
1150 17th Street, NW
Suite 202
Washington, DC 20036
(202) 429-0930

National Minority AIDS Council
300 I Street, NE
Fourth Floor
Washington, DC 20002
(202) 544-1076

National Network of Runaway and Youth Services
1400 I Street, NW
Suite 330
Washington, DC 20005
(202) 682-4114

The National PTA
700 North Rush Street
Chicago, IL 60611-2571
(312) 787-0977

National Rural and Small Schools Consortium
Western Washington University
Miller Hall Room 359
Bellingham, WA 98224
(206) 676-3476

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722

National Safety Council
P.O. Box 11933
Chicago, IL 60611
(312) 527-4800
(800) 621-7619

National Urban League
500 East 62nd Street
New York, NY 10021
(212) 310-9000

Parents and Friends of Lesbians and Gays (P-FLAG)
P.O. Box 28009
Washington, DC 20038
(202) 638-4200

Planned Parenthood Federation of America
810 7th Avenue
New York, NY 10019
(212) 603-4632

Presbyterian Church, USA
100 Witherspoon Street
Room 5429
Louisville, KY 40202-5497
(606) 870-2694

The Salvation Army
120 West 14th Street
New York, NY 10011
(212) 337-7202

San Francisco AIDS Foundation
333 Valencia Street
4th. Floor
San Francisco, CA 94103
(415) 864-5855

Sex Information and Education
Council of the United States
(SIECUS)
32 Washington Place
Room 52
New York, NY 10003
(212) 673-3850

Teens Teaching Teens About AIDS
The Good Samaritan Project
3940 Walnut
Kansas City, MO 64111
(816) 561-8784
HOTLINE: (800) 234-TEEN

United Church of Christ
110 Maryland Avenue, NE
Room 504
Washington, DC 20002
(202) 543-1517

United Methodist Church
Board of Global Ministries
Room 360
475 Riverside Drive
New York, NY 10115
(212) 870-3600

United States Catholic Conference
3211 Fourth Street, NE
Washington, DC 20017
(202) 541-3000

U.S. Conference of Mayors
1620 I Street, NW
Washington, DC 20006
(202) 293-7330

U.S. Department of Health
and Human Services
Public Health Service, Centers for
Disease Control
National AIDS Informtion/Education
Program
1600 Clifton Road, NE
MSG 29
Atlanta, GA 30333
(404) 639-2076

U.S. Department of Health
and Human Services
Public Health Service
Office of Minority Health
Resource Center
200 Independence Avenue, SW
Room 118-F
Washington, DC 20201
(202) 245-0020

U.S. Department of Health
and Human Services
Public Health Service
Health Resources and Services
Administration
Bureau of Maternal and Child Health
and Resources
Parklawn Building, Room 9-11
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2170

United Way of America
Community Initiatives Division
701 North Fairfax Street
Alexandria, VA 22314-2045
(703) 836-7100

YWCA of the U.S.A.
726 Broadway
New York, NY 10003
(212) 614-2700

Current and Forthcoming Publications from CPO

Resources: Adolescents, AIDS and HIV

Peer Education: Teens Teaching Teens About AIDS and HIV Infection Prevention—A detailed analysis of peer education theory and strategy, including practical information about setting up programs. (May 1989) $5.00

Resources for Educators—An annotated bibliography of quality education materials about HIV and AIDS. (Fourth edition, October 1989) $3.50.

The Facts: Adolescents, AIDS and HIV—A concise statistical fact sheet about the HIV epidemic as it relates to teens. (Updated regularly) First copy free, bulk rate available.

Advice from TEENS...on Buying Condoms—Written by teens for teens, this pamphlet uses cartoons and simple language to address the confusion, nervousness and fear that many teens experience when purchasing condoms. (1988) $.25 Bulk rate available.

Out of the Shadows: Strategies for HIV Prevention in Street Youth—The product of a conference on street youth convened by CPO, this report profiles adolescents on the street, the risks associated with their lifestyle, and strategies for preventing HIV infection among this forgotten population. (November 1989)

Life Planning Education

Life Planning Education Curriculum—CPO's innovative curriculum integrates sexuality education and employment planning. (Revised 1988) $35.00

Make a Life for Yourself—A booklet for teens, with ideas from the Life Planning curriculum demonstrated through fun, self-guided exercises. (Revised March 1989) $1.00 Bulk rate available.

Research and Analysis

Teens' Survey of Stores in the District of Columbia on Accessibility of Family Planning Methods—CPO's Teen Council conducted the research for this report, surveying the accessibility of condoms and other contraceptives in 60 drug and convenience stores in Washington, DC. (1988) $1.00

D.C. Teenagers and AIDS: Knowledge, Attitudes and Behavior—This analysis of four focus groups of Washington, D.C. teenagers shows that teens who know the facts about AIDS and HIV infection do not necessarily change their behavior. (1988) $1.00

Center for Population Options

The Center for Population Options is a nonprofit educational organization dedicated to improving the quality of life for adolescents by preventing too-early childbearing. CPO's national and international programs seek to improve adolescent decision-making through "life planning" and other educational programs, to improve access to reproductive health care, to promote the development of school-based clinics, and to prevent the spread among adolescents of HIV and other sexually transmitted diseases. CPO's National Initiative on Adolescents, AIDS and HIV promotes exchange of information and development of innovative strategies to prevent the HIV epidemic from reaching young people.

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